24

24 Maternity Care Program

The Alabama Medicaid Maternity Care Program allows Medicaid to establish locally coordinated systems of care, in which targeted populations receive maternity care in environments that emphasize quality, access, and cost-effective care.

The purpose of this managed care effort is to ensure that every pregnant woman has access to medical care, with the goal of lowering Alabama's infant mortality rate and improving maternal and infant health.

In most cases the Primary Contractor develops subcontracts with other providers capable of providing the requisite services. The responsibility remains with the Primary Contractor to assure qualitative and quantitative adequacy of the service.

Policy provisions for Maternity Care are found in the *Maternity Care Operational Manual* published by the Alabama Medicaid Agency and in the *Alabama Medicaid Agency Administrative Code,* Chapter 45. Both of these documents are available on the Medicaid web page.

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24.1 Enrollment

The Alabama Medicaid Agency selects Primary Contractors for the Maternity Care Program through a competitive bid process. Contractors must meet the licensure certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Provider Number, Type, and Specialty

Primary Contractors are enrolled by Medicaid's Medical Services Division as maternity care providers and issued a nine-digit Alabama Medicaid provider number that enables them to submit requests and receive reimbursements for maternity care services.

NOTE:

All nine digits are required when filing a claim.

Maternity care providers are assigned a provider type of Maternity Care (87). The valid specialty for maternity care providers is Maternity Care Program (M6).

Districts

Medicaid has established maternity care districts. Potential Primary Contractors must show that a care system operates in the entire district. Contractors are required to provide maternity care services to most women eligible for maternity care in the specified district.

Providers should advise recipients that if they intentionally go outside of the provider network for non-emergency care, the recipient must pay the bill if they do not get approval from the Primary Contractor.

District	***Counties***
District 1	Colbert, Franklin, Lauderdale, Marion
District 2	Jackson, Lawrence, Limestone, Madison, Marshall, Morgan
District 3	Calhoun, Cherokee, Cleburne, DeKalb, Etowah
District 4	Bibb, Fayette, Lamar, Pickens, Tuscaloosa
District 5	Blount, Chilton, Cullman, Jefferson, Shelby, St. Clair, Walker, Winston
District 6	Clay, Coosa, Randolph, Talladega, Tallapoosa
District 7	Greene, Hale
District 8	Choctaw, Marengo, Sumter
District 9	Dallas, Wilcox, Perry
District 10	Autauga, Bullock, Butler, Crenshaw, Elmore, Lowndes, Montgomery, Pike
District 11	Barbour, Chambers, Lee, Macon, Russell
District 12	Baldwin, Clarke, Conecuh, Covington, Escambia, Monroe, Washington
District 13	Coffee, Dale, Geneva, Henry, Houston
District 14	Mobile

Added: This is the…Medicaid web page.

Contact information for primary care contractors for each district displays below: This is the list of current providers through July 31, 2005. On August 1, 2005, please note changes for Districts Three and Nine. Districts One and Two have been awarded to the incumbent, HealthGroup of Alabama. There may be other changes dependent upon re-bid results. Please consult the Medicaid web page.

Added: District 1-08/01/05

Added: District 2-08/01/05

Added: District 3-Viva Health Administration LLC

Deleted (District 6)-~~Rhonda Boswell~~
Added: Rhonda Flanagan

Added: District 9-Viva Health Administration LLC

District	***Primary Contractor***	***Phone Number For Recipients***	***Phone Number For Providers***	***1-800 Phone Number***	***Start Date***
District 1	HealthGroup of Alabama	(256) 265-7155	(256) 265-7458 Laura Thompson	1-888-500-7343	07/01/02 08/01/05
District 2	HealthGroup of Alabama	(256) 265-7155	(256) 265-7458 Laura Thompson	1-888-500-7343	07/01/02 08/01/05
District 3	Quality of Life	(256) 492- 0131	(256) 492-0131 Amelia Wofford	1-888-490-0131	06/01/02
District 3 Effective 8/1/05	Viva Health Administration LLC	(205) 558-7405 or 1-877-997--8377	(205) 558-74-39 Nancy Reamsma	1-877-997-8377	08/01/05
District 4	Alabama Health Network	(205) 345-1905	(205) 345-5205 Becky Henderson	1-877-533-4485	06/01/02
District 5	Alabama Maternity, Inc. (VIVA Health)	(205) 558-7405	(205) 558-7406 Libba Yates	1-877-997-8377	06/01/02
District 6	Gift of Life Foundation	(334) 272-1820	(334) 272-1820 Rhonda Flanagan	1-877-826-2229	06/01/02
District 7	Alabama Health Network	(205) 345-1905	(205) 345-5205 Becky Henderson	1-877-553-4485	06/01/02
District 8	Bryan Whitfield Memorial Hospital	(334) 287-2675	(334) 287-2675 Marcia Lankster	1-888-531-6262	06/01/02
District 9	Alabama Health Network	(205) 345-1905	(205) 345-5205 Becky Henderson	1-877-553-4485	06/01/02
District 9 Effective 8/01/05	Viva Health Administration LLC	(205) 558-7405 or 1-877-997-8377	(205) 558-7439 Nancy Reamsma	1-877-997-8377	08/01/05

District	*Primary Contractor*	*Phone Number For Recipients*	*Phone Number For Providers*	*1-800 Phone Number*	*Start Date*
District 10	Gift of Life Foundation	(334) 272-1820	(334) 272-1820 Martha Jinright	1-877-826-2229	06/01/02
District 11	Maternity Services of District 11	(334) 291-5300	(334)291-5324 Donna Guinn-Taylor	1-877-503-2259	06/01/02
District 12	Southwest Alabama Maternity Care Program	(334) 743-7498	(251) 575-7062 Jeanette Gibson	1-877-826-2229	06/01/02
District 13	Southeast Alabama Maternity Care Program	(334) 712-3784	(334) 712-3784 Gary Bennett	1-800-735-4998	06/01/02
District 14	USA Medical Center	(251) 415-8585	(251) 415-8585 Susan Eschete	n/a	10/01/02

24.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

24.2.1 Eligibility

The following recipients are required to participate in the Maternity Care Program:

- Those certified through the SOBRA Program
- Those certified through the Medicaid for Low Income Families (MLIF) Program (formerly AFDC)
- Refugees
- SSI eligible women 19 and over at time of enrollment

The following recipients are not required to participate:

- Indians who are members of a federally recognized tribe
- Children under the age of 19, at time of enrollment, who meet any of the following criteria:
  - Persons eligible for SSI under Title XIX
  - Persons in foster care or other out of home placement, such as Department of Youth Services (DYS)
  - Persons receiving foster care or adoption assistance
  - Persons receiving services through a family centered, community based, coordinated system of care receiving grant funds (Special Needs)
- Women enrolled in a private HMO
- Those persons described in Section 1902(e)(3) of the Act

Medicaid recipients who are not required to participate may participate on a voluntary basis. If the recipient elects to participate in the program, Medicaid pays for services through the Maternity Care Program.

The following recipients will not be allowed to participate, and shall not be enrolled in the Maternity Care Program. The maternity services for these recipients are provided through fee-for-service.

- Dual recipients (Medicare/Medicaid)

24.2.2 Covered Services

The Primary Contractor is responsible for all pregnancy-related care including high-risk care from the 1st of the month in which the woman is certified until the end of the month in which the 60th postpartum day falls. This section contains information about the following services covered under the global fee:

- Antepartum care
- Outpatient care (except for services received in an emergency room)
- Delivery
- Hospitalization (except in instances where the recipient exceeds in-patient days)
- Postpartum care
- Care coordination services
- Assistant Surgeon Fees
- Associated services
- Anesthesia services
- Home visits
- Ultrasounds

Antepartum Care

Antepartum care includes the following usual prenatal services:

- Initial visit at the time pregnancy is diagnosed
- Initial and subsequent histories
- Maternity counseling
- Risk assessments
- Physical exams
- Recording of weight
- Blood pressure recordings
- Fetal heart tones
- Lab work appropriate to the level of care including hematocrit and chemical urinalysis

Delivery

Delivery includes vaginal delivery, with or without episiotomy, with or without forceps or cesarean section delivery. More than one fee **may not** be billed for a multiple birth delivery. Delivery includes, but is not limited to, hospitalization, routine newborn care, and professional services, such as anesthesiology. Any non-routine newborn care must be billed under the baby's Medicaid number.

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Hospitalization

Hospitalization includes delivery as well as any pregnancy-related hospitalizations, as defined in the *Maternity Care Operational Manual*, that occur in the antepartum period or postpartum period. Hospitalization includes all charges that are normally submitted on the uniform billing claim form (UB-92), which includes but is not limited to the following:

- Labor
- Delivery or operating room
- Room and board including well baby nursery days
- Drugs, supplies, and lab/radiology services obtained during hospitalization

NOTE:

Sterilization procedures performed during delivery stays are included as covered services under the global fee and may not be billed separately by the hospital. Physician sterilization charges may be billed fee-for-service.

Outpatient

Outpatient includes any pregnancy-related outpatient services except for those in the emergency room or labor and delivery suite for pregnancy-related care (for example, non-stress tests and false labor).

Postpartum Care

Postpartum care includes office visits, home visits, and in-hospital visits following delivery for routine care through the end of the month of the 60-day postpartum period. The postpartum exam should be accomplished four to eight weeks after delivery.

Care Coordination Services

The care coordinator arranges a coordinated system of obstetrical care for pregnant women. Refer to the *Maternity Care Operational Manual* for specifics on care coordination services requirements.

Assistant Surgeon Fees

The global rate includes assistant surgeon fees for cesarean (c-section) deliveries.

Associated Services

The global fee includes all services associated with treatment of the pregnancy during the antepartum and postpartum period including, but not limited to colposcopy, EKGs, cerclages, and medical services performed in an outpatient setting (except lab and radiology procedures other than ultrasounds). Refer to table on 25.5.4 for details.

Anesthesia Services

Anesthesia services include anesthesia services performed by an anesthesiologist or the delivering physician that are not medically contraindicated.

Home Visits

Home visits are not skilled care nursing visits. Maternity Care Program home visits are for evaluation, assessment and referral and are accomplished by social workers or nurses. These visits are performed in accordance with the priority criteria provided in *the Maternity Care Operational Manual*.

Ultrasounds

Medicaid pays for obstetrical ultrasounds for reasons of medical necessity. Payment will **not** be made to determine only the sex of the infant.

Primary Contractors in each district are financially responsible for the first seven ultrasounds for reasons of medical necessity for each pregnancy. It is the Primary Contractor's responsibility to maintain a record of the dates of all ultrasounds for each pregnancy. Medicaid's Prior Authorization Unit (PA) has the ability to authorize additional ultrasounds (number 8 and above) based on the recipients medical condition. The ultrasounds approved for payment by the PA Unit will be paid fee-for-service by Medicaid.

The following required information shall accompany all ultrasound requests for authorization:

- Date of the requested ultrasound
- Date of the request
- A list of **all dates of prior ultrasounds** for the current pregnancy
- Recipient's date of birth and Medicaid number
- EDC-Estimated Date of Confinement
- Medical diagnosis to substantiate the ultrasound that is being requested
- Benefit of the ultrasound that is being requested
- Anticipated total number of ultrasounds for the current pregnancy

PA requests shall be submitted to EDS following normal PA procedures.

Separately Billable Services

Services provided outside the scope of the global fee that may be billed separately are listed below:

Separately Billable Service	*Description*
Drugs	Family planning or general drugs (for example, oral contraceptives or iron pills) prescribed by a provider with a written prescription to be filled later may be billed on a fee-for-service basis. Injections administered by the physician or outpatient facility can be billed on a fee-for-service basis (for example, Rhogam or Iron).
Lab Services	All lab services except hemoglobin, hematocrit, and chemical urinalysis.
Radiology	All radiology services are outside of the global fee unless performed during an inpatient stay or for ultrasounds and non-stress tests.
Dental	Dental services are covered for recipients under 21 years of age. For SOBRA-eligible recipients, services must be pregnancy-related.
Physician	Physician fees for family planning procedures (for example, sterilization), and genetic counseling. Claims for circumcision, routine newborn care, standby and infant resuscitation may be billed under the mother's name and number on a fee-for-service basis.
Family Planning Services	Any claim with a family planning procedure code or indicator, with the exception of hospital claims for sterilization procedures performed during the delivery stay may be billed on a fee-for-service basis.
Emergency Services	Outpatient emergency room services (including the physician component) (claims containing a facility fee charge of 99281, 99282, 99283, 99284, or 99285) and associated physician charges (99281-99288) will be reimbursed separately from the global fee. Access to emergency services will not be restricted by the Maternity Care Program.
Transportation	Transportation as allowed under the Alabama Medicaid State Plan may be billed on a fee-for-service basis.
Fees for Dropouts	All services provided to dropouts should be billed fee-for-service. However, the provider of service must submit the claims to the Primary Contractor for Administrative Review. Appropriate claims will then be referred to Medicaid by the Primary Contractor.
Mental Health	Mental health visits for the purpose of outpatient mental health services may be billed on a fee-for-service basis.
Miscarriages less than 21 weeks	All services may be billed fee-for-service. If the claim does not contain the miscarriage diagnosis code, it must be sent to the Primary-Contractor, who must submit an Administrative Review Form to the Alabama Medicaid Agency prior to the services being billed fee-for-service.
Referral to Specialists	Services provided by non-OB specialty physicians (i.e. cardiologists, endocrinologists) for problems complicated or exacerbated by pregnancy can be billed fee-for-service by the provider of service. A general/family practitioner or perinatologist is not considered a specialty provider.
Exemptions	Claims for women who are granted an exemption may be billed fee-for-service. The Primary contractor must submit an Administrative Review Form to the Alabama Medicaid Agency and get approval for the exemption prior to the claims being billed.
Non-Pregnancy Related Care	Services provided that are not pregnancy-related are the responsibility of the beneficiary unless she is eligible under regular Medicaid benefits.

24.3 Prior Authorization and Referral Requirements

Primary Contractors generally do not require prior authorization for billing covered services to EDS.

24.4 Cost Sharing (Copayment)

Copayment does not apply to services provided for pregnant women.

24.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

➢Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

Primary Contractors who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

24.5.1 Time Limit for Filing Claims

Medicaid requires all claims from Primary Contractors to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

24.5.2 Diagnosis Codes

Primary Contractors are to bill all claims to EDS utilizing the appropriate CPT code. **A pregnancy diagnosis code, primary or secondary, must be used when billing maternity care services**.

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

24.5.3 Procedure Codes and Modifiers

The (837) Professional and Institutional electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers. Claims for maternity care services are limited to the following five procedure codes and modifiers:

Code	*Modifier*	*Description*
59400		Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy or forceps) and postpartum care.
59410		Vaginal delivery and postpartum care only.
59510		Routine obstetric care including antepartum care, cesarean delivery and postpartum care.
59515		Cesarean delivery and postpartum care only
99199		Maternity Care Drop-Out Fee. Patient must have enrolled with their district of residence Primary Contractor prior to delivery.

Reimbursement for Services

Global/delivery-only fees paid by Medicaid to the Primary Contractor represent payment in full. Recipients may not be billed for any services **covered** under this program. Delivery-only fees paid by Medicaid to the Primary Contractor represent payment in full for all services provided from the time of delivery through the postpartum period. Recipients may be billed for services provided prior to the time of delivery.

For recipients who receive total care through the Primary Contractor network, a global fee should be billed.

For recipients who receive no prenatal care through the Primary Contractor's network, a delivery-only fee must be billed. The components of the delivery-only fee include those services provided from the time of delivery through the postpartum period.

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24.5.4 Associated Codes

The following services are considered associated codes and are included in the global fee:

Procedure Code	Description
99212-HD	Prenatal Visit
59430	Postpartum Care
00842	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; amniocentesis
00850	To report use 01961
00587	To report use 01968
00940	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium)
00942	Anesthesia for colpotomy, vaginectomy, colporrhaphy, and open urethral procedures)
00948	Anesthesia for cervical cerclage)
00950	Anesthesia for culdoscopy)
00952	Anesthesia for hysteroscopy and/or hysterosalpingography)
00955	To report use 01967
01960	Anesthesia for; vaginal delivery only
01961	Anesthesia for; cesarean delivery only

Procedure Code	Description
01967	Neuraxial labor analgesia/anesthesia for planned vaginal delivery
01968	Anesthesia for c-section delivery following neuraxial labor . . .
10140	Incision and drainage of hematoma, seroma, or fluid collection
10160	Puncture aspiration of abscess, hematoma, bulla, or cyst
10180	Incision and drainage, complex, postoperative wound infection
49020	Drainage of peritoneal abscess or localized peritonitis
49060	Drainage of retroperitoneal abscess; open
49320	Laparoscopy
49322	Laparoscopy with aspiration of cavity or cyst (e.g., ovarian cyst) (single or multiple)
56405	Incision and drainage of vulva or perineal abscess
56420	Incision and drainage of Bartholin's gland abscess
56440	Marsupialization of Bartholin's gland cyst
56441	Lysis of labial adhesions
56820	Coloscopy of the vulva
56821	Coloscopy of the vulva with biopsy
57000	Colpotomy; with exploration
57010	Colpotomy
57020	Colpocentesis (separate procedure)
57022	Incision and drainage of vaginal hematoma; obstetrical/postpartum
57150	Irrigation of vagina and/or application of medicament
57400	Dilation of vagina under anesthesia
57410	Pelvic examination under anesthesia
57415	Removal of impacted vaginal foreign body (separate procedure) under anesthesia
57460	Colposcopy of the cervix including upper/adjacent vagina
58660	Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)
59000	Amniocentesis, any method
59001	Therapeutic amniotic fluid reduction
59012	Cordocentesis (intrauterine), any method
59015	Chorionic villus sampling any method
59020	Fetal contraction stress test
59025	Fetal non-stress test
59030	Fetal scalp blood sampling
59050	Fetal monitoring during labor by consulting physician (i.e., non-attending physician) with written report; interpretation only
59051	Fetal monitoring during labor by consulting physician (i.e., non-attending physician) with written report; supervision and interpretation
59160	Curettage, postpartum
59200	Insertion of cervical dilator (e.g., laminaria, prostaglandin)
59300	Episiotomy or vaginal repair by other than attending physician
59320	Cerclage of cervix, during pregnancy
59325	Cerclage of cervix, during pregnancy; abdominal
59350	Hysterorrhaphy of ruptured uterus

Procedure Code	Description
59400	Routine obstetric care includes antepartum care, vaginal delivery (with or without episiotomy and/or forceps) and postpartum care
59409	Vaginal delivery only
59410	Vaginal delivery only (with or without episiotomy and/or forceps), including postpartum care
59414	Delivery of placenta following delivery of infant outside of hospital
59425	Antepartum care only (4 to 6 visits)
59426	Antepartum care only (7 or more visits)
59430	Postpartum care only
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
59514	Cesarean delivery only
59515	Cesarean delivery only; including postpartum care
59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy and/or forceps) and postpartum care, after previous cesarean delivery
59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)
59614	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care
59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery
59620	Cesarean delivery only , following attempted vaginal delivery after previous cesarean delivery
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery, including postpartum care
59871	Removal of cerclage suture under anesthesia
59898	Unlisted laparoscopy procedure, maternity care and delivery
76801	Ultrasound, pregnant uterus, real time image with documentation, with fetal and maternal evaluation
76802	Ultrasound, pregnant uterus, real time image documentation, with fetal and maternal evaluation
76805	Ultrasound, pregnant uterus, B-scan and/or real time with imagine documentation; complete
76810	Ultrasound, complete, multiple gestation, after the first trimester
76811	Ultrasound, pregnant uterus, real time image with documentation, with fetal and maternal evaluation
76812	Ultrasound, pregnant uterus, real time image with documentation, with fetal and maternal evaluation
76815	Ultrasound, limited (fetal size, heartbeat, placental location, fetal position, or emergency in the delivery room)
76816	Ultrasound, follow-up or repeat
76817	Ultrasound, pregnant uterus, real time with image documentation, transvaginal
76818	Fetal biophysical profile
76819	Fetal biophysical profile; without non-stress testing
76825	Echocardiography, fetal
76826	Echocardiography, fetal, follow-up or repeat study
76827	Doppler echocardiography, fetal
76828	Doppler echocardiography, fetal, follow-up or repeat study
76830	Ultrasound, transvaginal
81000	Urinalysis, by dipstick or tablet reagent
81001	Urinalysis, automated, with microscopy

Procedure Code	Description
81002	Urinalysis, non-automated, without microscopy
81003	Urinalysis, automated, without microscopy
81005	Urinalysis; qualitative or semiquantitative, except immunoassays
81007	Urinalysis; bacteriuria screen, except by culture or dip stick
81015	Urinalysis; microscopic only
81020	Urinalysis; two or three glass test
81099	Unlisted urinalysis procedure
83026	Hemoglobin, by copper sulfate method, non-automated
83036	Hemoglobin, glycated
85014	Blood count; other than spun hematocrit
85018	Blood count; hemoglobin
99050	Services requested after office hours in addition to basic
99052	Services requested between 10:00 PM and 8:00 AM
99054	Services requested on Sundays and holidays in addition
99058	Office services provided on an emergency basis
99201	Office or other outpatient visit for E&M
99202	Office or other outpatient visit for E&M
99203	Office or other outpatient visit for E&M
99204	Office or other outpatient visit for E&M
99205	Office or other outpatient visit for E&M
99211	Office or other outpatient visit for E&M
99212	Office or other outpatient visit for E&M
99213	Office or other outpatient visit for E&M
99214	Office or other outpatient visit for E&M
99215	Office or other outpatient visit for E&M
99217	Observation care discharge day management
99218	Initial observation care, per day, for E&M
99219	Initial observation care, per day, for E&M
99220	Initial observation care, per day, for E&M
99221	Initial hospital care, per day, for E&M
99222	Initial hospital care, per day, for E&M
99223	Initial hospital care, per day, for E&M
99231	Subsequent hospital care, per day, for E&M
99232	Subsequent hospital care, per day, for E&M
99233	Subsequent hospital care, per day, for E&M
99238	Hospital discharge day management; 30 minutes or less
99239	Hospital discharge day management; more than 30 minutes
99241	Office consultation for a new or established patient
99242	Office consultation for a new or established patient
99243	Office consultation for a new or established patient
99244	Office consultation for a new or established patient
99245	Office consultation for a new or established patient

Procedure Code	Description
99251	Initial inpatient consultation for a new or established patient
99252	Initial inpatient consultation for a new or established patient
99253	Initial inpatient consultation for a new or established patient
99254	Initial inpatient consultation for a new or established patient
99255	Initial inpatient consultation for a new or established patient
99261	Follow-up inpatient consultation for an established patient
99262	Follow-up inpatient consultation for an established patient
99263	Follow-up inpatient consultation for an established patient
99271	Confirmatory consultation for a new or established patient
99272	Confirmatory consultation for a new or established patient
99273	Confirmatory consultation for a new or established patient
99274	Confirmatory consultation for a patient
99275	Confirmatory consultation for a patient
99354	Prolonged physician service in the office or other outpatient setting; first hour
99355	Prolonged physician service in the office or other outpatient setting; each additional 30 minutes
99356	Prolonged physician service in the inpatient setting; first hour
99357	Prolonged physician service in the inpatient setting; each additional 30 minutes

NOTE:

The global fee includes the associated codes and the maternity care codes.

24.5.5 Place of Service Codes

The following place of service code applies when filing claims for maternity care services:

POS Code	*Description*
21	Inpatient Hospital

24.5.6 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

24.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

24.7 Local Codes Crosswalk Information

NOTE:

Use "Local" procedure codes for **dates of services** through 12/31/03. Use HCPCS procedure code, with modifier(s) if applicable, for dates of service 01/01/04 and thereafter.

"Local" Code thru 12/31/03	HCPSC-Modifier(s) Beginning 01/01/04	Description
Z5185	99212-HD	Prenatal Visit
Z5195	59430	Postpartum Care
Z5382	99199	Administrative and Care Coordinated Services (for patients who do not complete the requirements of the Maternity Waiver Program)